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THE LINACRE QUARTERLY

MAY, 1953

Ethical Principles Applied to Extensive Palliative Abdominal Operations

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Boston, Massachusetts

PRESENT day advances in surgical technique, parenteral fluid and blood replacement, anesthesia, antibiotics and general medical knowledge have extended the field of abdominal operations. This applies clinically to surgical procedures from the curative or palliative viewpoint. Extensive surgery has been particularly developed as pertains to abdominal cancer located in the bladder, uterus, genital organs, rectum, stomach, pancreas, kidney, and retroperitoneal structures. The ethical position of these operative procedures, when applied in a clinical curative sense, has been well developed and accepted. The performance of such extensive procedures in more recent years, where the decision to operate is based on easing distress rather than cure, has been used, to varying extent, in different institutions. In illustrating extensive abdominal procedures, which may be performed for palliative reasons, one may list the following examples: rectal cancer surgery with removal of the rectum and colostomy formation; bladder cancer surgery where cystectomy may be performed with implantation of the ureters in the sigmoid colon; uterine or ovarian malignancy where the uterus, adnexae, lymphnodes, fascial structures and possibly rectum or bladder may be removed; nephrectomy in the presence of varying amounts of pulmonary cancer spread. The surgical judgment whereby such procedures palliate is most difficult, and it is the purpose of this article to consider the ethical principles which serve to formulate this.

Surgeons of Catholic faith have been guided in medico-moral principles by several Diocesan medical, surgical, and hospital codes: "The Surgical Code of the Catholic Hospital Association of the United States and Canada" and the more recent review called "Ethical and Religious Directives for Catholic Hospitals," dated 1949. These moral principles and practical applications have religious authority and a scientific basis insofar as they represent expressions of the natural law. Abdominal surgery, ethically, is considered under the subject of mutilation. Such single operative procedures as removal of the appendix and gallbladder are licit in that such organs have a natural subordination to the good of the whole body. In such cases, the

evil of organ removal may be permitted directly for a proportionate benefit of the whole body. This is within man's own direct right. Certain organs within the body affect not only the person who possesses them but also others. The genital organs with the additional function of reproduction, pregnancy with the addition of a live fetus may serve as examples. Any operative procedure applied to these organs must be ethically justified by the moral principle of the double effect. The moral principle is that it is lawful to perform an action having two effects, one good and the other evil, when the following considerations are fulfilled. The operation, in itself, must be good or indifferent. The good effect obtained must follow as immediately from the procedure as the evil effect. The intention of the individual must be to bring about the good effect. There must be a proportionately grave cause for placing the act or operation.

A surgeon derives his rights immediately both from the patient and the State. He is licensed by the State following appropriate medical examination; and in return, the State protects the method of medical practice. The surgeon has a duty to practice according to the ethics of his profession. The surgeon has an implicit contract with the patient, ethically, to furnish services with diligence and skill in providing care for the patient. It is implied that cure in all cases may not be obtainable. In return for these services, he is entitled to some recompense. A surgeon is obligated to his patients ethically in that he renders professional services to the best of his ability, that he is solicitous for their spiritual welfare and that he maintains professional secrecy concerning the factors involved. The foregoing considerations serve as basic moral principles in morality of the surgery procedure and participating surgeon.

In any operative procedure, it is required that the consent, at least reasonably presumed, of the patient or of his guardian be obtained in all cases. Proper consent requires a basic understanding of the problem at hand, its reasonable effects on oneself, the length of hospitalization, the prospects for cure or palliation and any logical consequences of the same. A patient morally possesses the right of reasonable administration over his body, not one of absolute ownership. A person's duty of self-preservation does not morally extend beyond reasonable measures; and according to this principle, he or a surgeon may be correct in refusing surgery relative to palliative situations where simpler medical methods to accomplish this are available.

Progressing now to the application of the moral principles to the subject at hand, one may realize that the previous paragraphs have considered many of the basic moral principles concerning the surgical operation, the surgeon and the patient. Together these comprise the basic moral principles incorporated in surgical judgment. Surgical operations are permissible for propor-

tionate reasons that concern the preservation or the restoration of a person's well being. On such a basis, diseased or healthy organs may be removed or suppressed functionally when this is necessary for the removal or suppression of a threat to life or health. In all cases specifically concerned, there must be due proportion according to the principles of double effect, previously mentioned, between the good to be accomplished and the risk to be involved in it. Ethically, the direct killing of any innocent person, even at his own request, is always morally wrong. On the other hand, operative procedures that are justifiable for proportionate reasons may be ethically correct even when death may be the indirect, unintended result of the same. The specific instances in which extensive abdominal surgery might be anticipated in the abdomen for palliative reasons have been mentioned in the beginning. These situations primarily are concerned with cancer where spread has already occurred to distant organs such as the liver or lungs. When such primary lesions have caused clinical conditions such as intestinal obstruction, the indications for surgical intervention have been quite clear. There remain, however, a large number of patients who have primary cancers in the previously described locations which are not obstructive and in which the general debilitating effects of spread contrast in apparent equality with the disturbance of the local lesion. A patient may also have incidental heart or other disease which makes the surgical risk graver still. There remain certain operative risks, in the performance of extensive surgery for these lesions, peculiar to each case. There are some postoperative effects that are specific to each extensive procedure which should be known to the surgeons before the performance of these operations. A particular instance of this may be illustrated by the chemistry changes and significant instance of retrograde renal sepsis in many ureterosigmoidostomies. Again in these delicate equations of surgical judgment, there are many pain threshold and emotional considerations for which surgical procedures very often are the poorest type of solution. In situations such as these, the judgment as to whether to apply extensive abdominal surgery can be equivocal, and it is felt that moral principles sustain and define more clearly this difficult field of palliative surgical judgment.

In summary, the performance of surgery for primary tumor complications, directly threatening life of the patient despite tumor spread, has been generally appreciated. The decision to apply abdominal surgery of an extensive type to cancer lesions where spread has already occurred, similar to the techniques mentioned at the beginning of this paper, calls for surgical judgment of the most difficult type as to whether such procedures actually have proportionate reason for their performance or will significantly render the patient's terminus more comfortable. The preceding considerations have

defined the moral ethical principles that underlie surgical judgment in such cases. Previous to surgery in such cases, it is proper Catholic hospital directive that such cases have consultation with section chiefs or section members who have an extensive knowledge and impersonal judgment concerning such cases. Where medico-moral issues may be involved in organs such as the uterus or ovaries, appropriate chaplain consultations should be had beforehand. Both ethically and on sound scientific surgical judgment, extensive surgical procedures should be performed only for the proportionate good of the patient involved and not from the viewpoint of procedure application. Medical management, appropriate old and newer medications combined with personality management and spiritual guidance remain for many such cases preferable palliative procedure. It is felt, in summary, that in this field of difficult surgical judgment Catholic ethical principles afford a basis for good surgical judgment and emphasize the wisdom of the expression, "What is good medical ethics is good medicine."

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Medico-Moral Notes

GERALD KELLY, S.J.

EUCHARISTIC FAST

THOSE who have a copy of *Medico-Moral Problems IV*, will note that it contains an article on "The Fast Before Communion" (p. 42). This article explains the law of the Eucharistic fast, as well as the principal exemptions, as it existed prior to January 16, 1953. On this date the provisions of the Apostolic Constitution *Christus Dominus* and of the accompanying instruction by the Sacred Congregation of the Holy Office took effect. These provisions affect both the law and the exceptions. They concern evening Mass, privileges for priests who are to celebrate Mass, and privileges for the faithful who receive Communion. The bishops will explain the norms concerning evening Mass when they grant this permission; priests no doubt know the norms that apply to them. Doctors should know the privileges that might apply to themselves, nurses, and patients as regards the reception of Holy Communion. For this purpose, the following summary may be useful:

1. *For Everyone:* Plain water (i.e., water not mixed with any other substance) no longer violates the fast. It should be clearly understood that this applies to everyone and that *no necessity whatsoever* is required for taking advantage of it. Ordinary tap water in cities, even though purified by chemicals, is still plain water; and so too is the natural water in certain districts which has a mineral content.

2. *For the Sick:*

A. *If they are in danger of death:* Canon 858, §1, completely exempts those in danger of death from the duty of observing the Eucharistic fast. There is absolutely no restriction on this privilege as regards the quality of the food taken or the nature of the liquid taken. No permission is needed for its use. This provision of canon law has not been changed by the recent legislation.

B. *If they are not in danger of death, but their illness is such as to make the observance of the complete fast difficult:* With the approval of a confessor, these may receive Holy Communion after having taken refreshment or nourishment in liquid form and medicine in solid and liquid form. The illness need not be confining. There is no time limit on this privilege; the permitted liquids and medicine may be taken right up to the time of

receiving Communion. Any solids taken must be truly medicine. Alcoholic drinks may not be taken, even as medicine.

(From the text of the documents it is perfectly clear that the exclusion of alcoholic drinks means at least those things which go by the name of alcoholic beverages, such as wine and whisky. Although these things may have medicinal value, they may not be taken before Holy Communion in virtue of this privilege. It is not clear whether true medicine which happens to contain alcohol as one of its ingredients is also excluded. This point will very likely be clarified by the Holy See.)

3. *For the Faithful in Special Circumstances:*

By reason of special conditions that make the observance of the complete fast a serious inconvenience, the faithful may, with the approval of a confessor, receive Holy Communion after having taken non-alcoholic liquids. This privilege has a time limit; the complete fast must be kept during the hour immediately preceding the reception of Holy Communion. The special conditions that warrant the use of the privilege are three: (a) *fatiguing work* that must be done before receiving Communion—e.g., doctors called for an obstetrical case or surgery during the night; hospital personnel on night duty or on duty for some time in the early morning before Mass; (*b*) the necessity of waiting till *a late hour* before receiving Communion—e.g., those who must wait till a nine o'clock Mass; and (*c*) *a long journey* to be made to get to church—e.g., a walk of about 1¼ miles, an equivalent difficulty in some form of transportation.

Caution regarding 2B and 3: For use of the privileges outlined under 2B and 3, the approval of a confessor is absolutely essential. The approval must be had before Communion is received, but not necessarily before medicines or liquids are taken. For example, a patient who is brought into the hospital during the night could be given needed medicine after midnight with the understanding that, if he is to receive Holy Communion that morning, the case will first be presented to the chaplain or some other priest. The confessor's approval may be given in confession or outside of confession, and it may be given once and for all so that it holds good as long as the same conditions of illness or of other serious inconvenience last.

JEWISH ATTITUDES

I have received an interesting and informative brochure entitled *Problems of Jewish Family Life*, by the Very Reverend I. Jakobovits, B.A., Chief Rabbi of the Jewish Communities in Ireland. The first part of the brochure is an exhortation to strengthen Jewish family life by living it according to their religious principles. The major part is given to a comparison of Jewish

and Catholic (and to some extent Protestant) attitudes towards artificial insemination, birth control, embryotomy, and abortion. The comparison is factual, not controversial or critical.

The Jewish attitude on donor insemination is one of condemnation; but, as Rabbi Jakobovits points out, the condemnation is based rather on the possible abuses of the practice than on any firm and universal conviction of the intrinsic immorality of the practice. "Such human stud-farming," he writes, "exposes the society to the gravest dangers which can never be outweighed by the benefits that may accrue in individual cases." On the other hand, the consensus of traditional Rabbinic opinion would be against our own position that donor insemination is essentially adultery and therefore intrinsically immoral. As to insemination between husband and wife, Jewish authorities differ concerning the licitness of masturbation as a means of procuring the semen; the more common view seems to be that this procedure can be permitted "under certain circumstances and with suitable safeguards."

As for authoritative Jewish attitudes on contraception, it is difficult to make any unqualified statement. As Rabbi Jakobovits says, opinions vary widely. It seems safe to say, however, that contraception for any non-medical reason is not approved; on the other hand, for a definitely medical reason such as risk to the life of the mother, a limited practice of contraception seems to be allowed, provided each individual case is appraised by a rabbi. Regarding the use of rhythm, Rabbi Jakobovits believes it is consonant with authoritative Jewish teaching "to advise young people to seek medical guidance along these lines in circumstances which morally and religiously justify such negative precautions." But absolute continence "is considered as not only highly impracticable but, indeed, as contrary to Jewish law which demands of the husband that he fulfill his marital duties at regular intervals." In fact, this duty of sometimes using marriage rights is considered so sacred that divorce would be preferable to continuing a union which demands total continence.

These particularized statements about birth control practices are perhaps more than a little out of focus if not considered in the light of the Jewish attitude toward the large family. Rabbi Jakobovits stresses this in a paragraph which strikes me as well worth preserving.

"The factor which should be emphasized above all others," he writes, "is the positive attitude of Judaism towards large families. Unlike even Roman Catholicism, Jewish law regards the procreation of children as a cardinal duty, in fact as the first divine commandment given to man. People who refuse to put at least a son and a daughter into the world and thus replace themselves and those who combined to give birth to them are looked upon as social pariahs who reduce the glory of God and contribute to the extinction

of His human creatures. The Torah stresses the fact that every one of our matriarchs craved to be blessed with children after an agonizing period of barrenness so as to perpetuate this outlook from the very birth of our people. Moreover, the one- or two-children-system has proved destructive of the delights and attractions of true Jewish home life; this suicidal system has helped to displace the home as the center of Jewish life and to promote selfishness among parents and children alike, because neither are trained how to sacrifice things for other members of the family and society. Even more vital, perhaps, is the demographic factor. Few realize what scale of human reproduction will be required gradually to replace the disastrous losses inflicted upon our people through its three-fold decimation within the last decade. In terms of sheer survival no service to the Jewish cause can even remotely rival that rendered by the Jewish mother, and no money is more fruitfully invested than in the rearing and education of a large family."

From the foregoing it seems clear that, with the exception of their rejection of absolute continence and their guarded approval of contraception for medical reasons, the authoritative Jewish attitudes on family limitation are much like our own. But very fundamental indeed is the difference of attitudes on the inviolability of fetal life. "Jewish law," the author says, "does not attribute human inviolability to the unborn embryo even if it is viable, nor does it consider the vitality of the child as definitely established until its birth, or—in some cases—until it has lived for at least thirty days." For this reason, the Jewish attitude, unlike our own, would sanction the destruction of the unborn child in the (hypothetical) mother-or-child dilemma.

MATERNAL SAFETY

In recent years I have seen several tables of comparative statistics concerning maternal deaths in hospitals where therapeutic abortion is practised and in hospitals that exclude it. (Cf. *Hospital Progress*, April 1953, pp. 64-65.) These statistics show that the mother is at least as safe in hospitals that exclude therapeutic abortion as she is in those that allow it. However, the statistics cover only a limited area; and one can hardly read them without wishing we had something more extensive.

Dr. Roy J. Heffernan and Dr. William A. Lynch, who gave us the splendid article, "Is Therapeutic Abortion Scientifically Justified?" (LINACRE QUARTERLY, February, 1952), now provide us with the desired extensive survey. They sent questionnaires to 367 hospitals in this country and received replies from 171. One result of their survey is the following

table of *maternal mortality:*

	No Therapeutic Abortions			Therapeutic Abortions		
	Deaths	Deliveries	Rate/1000	Deaths	Deliveries	Rate/1000
1940-45	827	642,788	1.28	971	599,685	1.61
1946-50	642	1,038,201	.61	587	975,032	.61
Totals	1469	1,680,989	.87	1558	1,574,717	.98

This, and much other information about the survey, is in Dr. Heffernan's article, "The Nurse and Catholic Motherhood," in *The Catholic Nurse*, December 1952. (The printed totals contained what was obviously a typing error in the fifth column; hence I corrected it.) Dr. Heffernan notes that in the series there were 2,717 therapeutic abortions. If statistics mean anything at all, these were not only morally objectionable but scientifically unjustifiable as well.

"One of the most serious implications of this whole question," observes Dr. Heffernan, "is concerned with the training of the physician of tomorrow. This survey demonstrates that in at least seventy-nine teaching obstetrical clinics, the young doctor is taught, in effect, that in a not inconsiderable number of cases, no amount of prenatal care, no recourse, however great, to the armamentarium of modern medicine will avail him to the objectives of a live and well mother and baby. In effect, he is being taught that in 1 out of 418 obstetrical cases 'to heal the mother you must kill the baby.' This false philosophy is naturally being imparted to the nurses in these hospitals by the physicians instructing them."

THE CATHOLIC NURSE

The Catholic Nurse is the title of the new official journal of the National Council of Catholic Nurses of the U. S. A. The Most Reverend Richard J. Cushing, D.D., is the Editor-in-Chief, and will hold that post till 1954, when the Council will take over the work itself.

At the time I write, three numbers of the new magazine have been published. Each issue contains many items that would be of great interest to Catholic doctors. For instance, the September 1952, number has "Helping the Acute Alcoholic," by John C. Ford, S.J., and "Nursing and the Administration of Justice," by Richard Ford, M.D. Fr. Ford's article stresses the need of providing medical care for alcoholics in our general hospitals. Dr. Ford's very informative article shows how nurses (and this would also apply to doctors) can help in the administration of justice by the proper care of the clothing of injured persons, as well as of objects found on such persons, blood and urine specimens, and so forth. He also points out the great value of dying declarations as evidence in court.

LOBOTOMY RE-EXAMINED

Also in the first number of *The Catholic Nurse* is "Lobotomy Re-examined," by Hugh Bihler, S.J. Fr. Bihler had previously written about lobotomy and concluded that the operation is morally justifiable as a last resort in the case of hopeless psychotics. As regards neurotics, he preferred to reserve judgment until more information was available. In his second article Fr. Bihler presents a splendid survey of scientific works published in recent years. His concluding paragraphs are of sufficient value to warrant full quotation:

"What changes, if any, do the facts of lobotomy, as we know them today, suggest for our moral judgment of lobotomy? We should, I think, adopt an attitude of conservatism. The operation should never be taken lightly; in fact, it must remain a last resort measure. Tucker and Dynes ["Indications for Lobotomy" *Lahey Clinic Bulletin*, 6, Jan. 1949, pp. 95-96] adopt such a conservative attitude when they recommend it for those who suffer from chronic agitated depression, various kinds of schizophrenia with large emotional or paranoid elements. And here we are supposing that other therapies have failed. The same authors indicate that the condition of the patient should be such that he would not be expected to respond to any other type of treatment. The same authors allow it in the case of some chronic severe obsessive-compulsive and some chronic severe hypochrondriacal neuroses. But again, it is a question of cases that failed to respond to other therapies. Then there is the question of lobotomy for intractable pain due to metastatic malignant cancer, especially where the condition is linked with drug addiction. Tucker and Dynes would not consider the operation indicated where there is organic brain disease. There are other indications required: the degree of suffering and incapacity must be sufficient to justify the operation; the family situation should be favorable for the rehabilitation of the patient and finally the expected postoperative condition must be considered a sufficient improvement to justify the operation.

"The last condition raises problems for the neurosurgeon. But Schrader and Robinson ["An Evaluation of Pre-frontal Lobotomy through Ward Behavior," *J. of Abnorm. and Soc. Psychology*, 40, 1945, 61-69] have provided some criteria, based on preoperative adjustment in the hospital, which can provide a rational basis for predicting post-operative advantages.

"It is obvious that all persons who are to be lobotomized must be prepared for a fatal accident. And they should even be urged to make a will and set their estate in order. But, of course, these precautions hold for any major operation, except that in the case of lobotomy there may be a likelihood of personality impairment.

"In warranting these indications, I feel it necessary to assert that not any and every psychiatrist or neurosurgeon is to be entrusted with this operation. How can we judge? By the results of his previous work, with which one will wish to become acquainted."

Fr. Bihler is exceptionally well-informed on the scientific literature and exceptionally competent to evaluate it. That is why I quoted his conclusions at some length. These conclusions agree substantially with what moral theologians have said on the subject. The theological attitude has been conservative, but not negative. The facts seem to show that in some cases lobotomy, and similar operations, do more harm than good; they turn a man into a sort of vegetable. But the facts also indicate that when this happens it is because the operation has been too extensive. When the operation is properly performed on properly selected patients it can be beneficial in cases of mental illness and of intractable pain. In such cases, when less radical procedures are not available or would be useless, there is no moral objection to the operation. (For more on this topic, particularly with reference to the address of Pope Pius XII on experimental medicine, see *Theological Studies*, March 1953, pp. 44-45.)

Federation Executive Board Meeting Scheduled

The Executive Board of the Federation of Catholic Physicians' Guilds will meet at 9:30 a. m., June 3, 1953, at Hotel Commodore, New York City. Election of officers will take place at this meeting.

The Board comprises the elective officers of the Federation and one delegate from each active constituent Guild.

Nominations for new officers may be made before the above date. Mail names to the General Offices of The Federation of Catholic Physicians' Guilds, c/o Rev. J. J. Flanagan, S.J., 1438 So. Grand Blvd., St. Louis 4, Missouri.

Medical-Moral Problems in Neurosurgery

THOMAS P. R. HINCHEY, M.D.

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THE moral principles by which an action is judged are no different in neurosurgery than in other forms of medicine. It is only the application of these, and in the frequency of that application that we have any peculiar problem. Death is a hazard in so many neurosurgical procedures, that a conscientious man will hesitate to use them unless there is a specific indication. An example of this is in the use of cerebral arteriography, particularly in those beyond middle age where paralysis or death may result unless care is taken in choosing the candidates for it. Imagine what might happen if the internist or the general surgeon had to worry about the hazard of death every time he ordered a gall-bladder series!

Another example of this peculiarity in application, is in the closure of wounds. After incomplete removal of a malignant brain tumor, should the wound be closed tightly, including the dura and bone, or should a large opening be left in the dura and bone? If a tight closure is done, then death will ensue more rapidly, but if a large decompression is left, the patient may develop severe headaches when the tumor recurs and begins to bulge out through the defect. It may prolong his agony, and result in an ugly protrusion which in itself may be difficult to care for. Depending upon circumstances, a strong argument might be made for either procedure.

Although the principle that life must be preserved is our general rule, difficulties arise when applied to individual cases. On an island in the Pacific when penicillin is very scarce, the use of it in treating pneumonia in a patient with terminal cancer, might be considered unwarranted, particularly if there were others about whose lives could be saved by the small amount of penicillin available. The question of parenteral fluid administration and antibiotics in a doomed patient is common to all branches of medicine.

It is precisely because of this difficulty in application of principles that I have decided to discuss a type of disease frequently encountered by neurosurgeons, and consider the application of the broad principles to the individuals with this disease. We will also consider how advances in medicine may change one's decision. The discussion will be concerned with gross

congenital defects of the central nervous system which might be considered remediable by surgical means, viz.; meningoceles, meningomyoceles, encephaloceles and hydrocephalus.

In this group there will be cases where the decision to be reached regarding therapy is immediately obvious. The simple meningocele consists of a sac containing fluid which protrudes on the back through a defect in the boney lining of the spinal canal. The wall of the sac is made up of the membranous covering of the spinal cord, and may be very thin. If untreated, meningitis will almost surely occur due to leakage through the wall or rupture of it. To prevent this, operative excision of the sac is carried out and the wound closed tightly with fascia. Operative results are good in an uncomplicated meningocele, and the operation is relatively easy to perform. This then, is one instance where the decision is obvious.

A meningomyelocele is made up of the same things that are present in the more benign meningocele, and in addition has spinal cord elements present. It is almost always accompanied by paralysis of the legs, bowels, and bladder due to the lack of function in the cord. It is not infrequently associated with hydrocephalus, and let us say that there is a large degree of hydrocephalus. Occasionally there is also a defect in the development of the upper portion of the cervical spine, where the base of the brain is apparently being pulled down into the upper neck. A child with all these troubles would indeed have little hope of recovering even though he underwent at least three major operations. Most neurosurgeons would not attempt to operate on this infant. Indeed most authorities[1,2] feel that paralysis of the legs, bowels and bladder are in themselves a sufficiently strong contraindication to surgery on meningomyeloceles.

It is those who fall between the two extremes who give us the most concern. What should be done, for example, with the child who has a meningomyelocele with resulting paralysis of the legs, bladder and bowel, with no other apparent defect? Operative repair is difficult and even if successful he will probably still be at least partially paralyzed if not totally. Infants do not tolerate extensive procedures well, and will be a severe nursing problem post-operatively. Up until age three or four, he can be expected to be wet almost constantly because of urinary dribbling, and will be a big financial drain upon the family. When the child finally returns home, will the parents be able to provide the loving care needed by the patient and at the same time not deprive other children in the family of their just share of the parents attention? Because of its handicap will the child grow up an emotional cripple? This largely will depend on the ability of the parents to provide a fairly normal homelife. Will the family or some agency supply wheel chairs, leg braces, special shoes, teachers, rehabilitation facilities, etc.?

Above all, will this child develop hydrocephalus before it is a year old and thus, perhaps, vitiate all the previous effort expended in relieving the primary defect?

In spite of all these difficulties that result from an attempt to treat this disease by surgical intervention, the untreated infant will almost surely die. This is true of meningomyeloceles and the usual progressive hydrocephalic.

Let us consider some of the advances made in medicine in recent years which would make us somewhat less pessimistic about the outlook. The problem in treating hydrocephalics is to dispose of an excessive amount of cerebrospinal fluid that has collected in the ventricles of the brain, for a reason that is unknown to us. There are two general methods of diverting the fluid from the ventricles. In one, a kidney is removed, and a plastic catheter carries the fluid to the ureter and thence to the bladder where it is expelled with the urine. The other procedure attempts to conserve the fluid within the body, and so the catheter may be directed into the middle ear or into the abdomen. From the middle ear, it passes by way of the Eustachian tube into the pharynx and is swallowed like saliva. In this method, the child is exposed to the danger of developing a meningitis at any time he develops a cold or a middle ear infection.

In treating defects of the spinal canal and cord, the big advances have been in the development of the antibiotics and plastic surgery.[3] One of the main causes of failure, usually resulting in death has been infection at the operative site. This is due in part to the proximity of the wound to the rectum, but also to the fact that the wounds are often closed under tension. Now by swinging a skin flap, the defect left by the removal of the sac can be easily closed without tension, and antibiotics given to insure against secondary infection. In addition the rectum is walled off from the operative sight and the child allowed to lie on his abdomen until the wound heals.

One of the most remarkable advances has been in the field of physical medicine, which has been greatly stimulated by the warfare of the last decade. It involves many different techniques which vary from teaching an individual to manipulate his crutches and braces so that he can get into a movie seat, to teaching of knitting for manual dexterity. It is obviously slow and expensive, and requires well trained personnel, but much can be done with paralyzed adults and I am sure the same can be said of paralyzed children.

How, then are we to decide on the moral aspects of such surgery? Our inclination will be to attempt to save as many as possible by whatever means possible. However, we would not want to cause great financial, spiritual,

and emotional suffering in the family of the child involved. Therefore, what is our obligation?

As creatures of God we possess our bodies as tenants rather than as absolute owners in much the same way as did the foreign governments possess the ships they obtained from the United States in lend-lease during the last war. They were not to dispose of them under any conditions, but were obliged to maintain them in good condition consistent with their continued use as implements of war. However, when damaged severely in battle, they did not have to sacrifice all their personnel just to keep the ships going. In other words, the effort expended to maintain the ships had to be in proportion to the chances of restoring the ship to the point where it could carry out its normal purpose—fighting.

So too, as lessees and not absolute owners of our lives, we cannot terminate life, but must use available means to preserve it. In addition there must be a just proportion between the cost and effort required to preserve it, and the potentialities that would exist if that life were preserved. In determining the just proportion, there will be so many individual factors that no general statement can be made. However, we can consider the meaning of the phrase "available means" and can arrive at some general conclusions.

Moral theologians tell us that we must use "ordinary" means to preserve health and life. But after making that statement, they seem to scatter to the winds on defining "ordinary." Some have identified ordinary with natural and therefore nothing more than eating, drinking, sleeping, and exercising would be required, thus excluding the use of aspirin let alone major surgery. Others have said that means which involve excruciating pain, danger of death, excessive expense, or great subjective repugnance are extraordinary, and therefore need not be done. By far the best definition I have found, and incidentally the best discussion of the whole problem of ordinary and extraordinary means, is to be found in an article appearing in the *Linacre Quarterly*, February 1951 by Fr. Thomas J. O'Donnell, S.J.[4] "Ordinary Means might best be defined as those which are at hand and do not entail effort, suffering or expense beyond that which men would consider proper for a serious undertaking, according to the state of life of each individual." He then added: "Apart from subjective consideration of pain, expense, or personal abhorrence—most of the commonly available techniques of modern surgery and medicine should be classified as ordinary means of preserving life."

It is my feeling that with the advances in modern surgery, the availability of blood, antibiotics, bone banks, rehabilitation services, and good nursing care more of these children should be operated upon. Their outlook

should not suffer too much by comparison with some of the unfortunate children with cerebral palsy upon whom we do expend such effort. The actual operative procedures described would certainly fall within the definition of ordinary means. In treating a specific infant, the doctor with a good conscience must decide whether there is a just proportion between the effort that will be expended before the child reaches adolescence and the potentialities of the child when a semblance of health is restored to progress toward his ultimate end—personal sanctification.

SUMMARY

The medical-moral problems encountered in neurosurgery are not different in principle but only in the frequency of their application.

The problems involved in treating gross congenital defects of the central nervous system have been reviewed. As a general rule, surgical treatment is indicated because it can be considered to fall within the definition of "ordinary means" required to maintain life.

The neurosurgeon must then decide on the basis of all the factors involved whether there is a just proportion between the effort expended, and the result to be obtained.

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The Formation of the Catholic Doctor

PAUL J. SCHMIDT

For the Executive Committee Associated Medical Newman Clubs
Bellevue Hospital, New York City

THE problem of the Catholic attending the non-Catholic University has been much discussed. We, as Catholic medical students would like to indicate what we have felt to be our special problem, and from our experience make some suggestions for its solution.

The student-physician is in a field, the principles of which are taught as much from people as from books, and he spends much time thinking about and discussing personalities, convictions, attitudes and ethics. Depending upon his orientation, the student variously fits these into a medical attitude of his own. Together with scientific facts they form his 'armamentarium' for his life's work.

But to this training the Catholic should add more. He should also use his experiences as tools in the formation of a new spiritual attitude. This attitude should enable him to see his patient not only as a sick human being, but a human being who is part of God's greater Plan; and himself as only an agent in that Plan. This new spiritual attitude, his new personal faith, together with his medical attitude are his own professional attitude.

Mostly the growth of the new spiritual life does not keep pace with the medical metamorphosis in the student. It may be years before, as a busy physician, he realizes that while he was studying bodies, he neglected the growth and development of his own soul. Far too many such as he will never then find time for spiritual ripening; or worse, the fruit will decay. Far too few will have been able to heighten themselves spiritually as they broadened themselves medically, maintaining always a religious and moral outlook in balance with their degree of medical training.

At the medical schools there are learned faculties only too willing to aid the student in attaining his new mode of material existence; but who will aid him in attaining the new ethical, social and religious way of life that should also now be his? Yet, few are the clergy who understand the problem, fewer the Catholic doctors who will help.

Mutual student cooperation in religious formation would seem to be the answer. But the student is a wayfarer and from class to class, group to group, activity varies. We would like to tell you of such a group, the Associated Medical Newman Clubs.

This organization was formed in the Spring of 1951 at a meeting in the Bellevue Hospital Catholic Medical Library of students from four of the five medical schools in New York City, all of which are non-sectarian. The purpose was to integrate the activities of the Catholic groups at these schools in the hope that by combining sporadic efforts some continuous activity might effectively result. Originally we had intended to form an extensive, even national, organization of Catholic medical students, but then we decided to anchor in already existing institutions, the local Medical Newman Clubs. Some of the individual clubs included nursing students, some had university affiliations, others had no formal structure, and thus the Associated Medical Newman Clubs became of necessity a liaison organization.

Our major activity has been a series of Clinical Ethical Conferences, patterned after the traditional Clinical Pathological Conference, at which case reports, expert medical opinion and ethical analysis of current medico-moral problems have been offered and discussed. These programs have reached a city-wide audience of students and physicians who have declared themselves strongly for continuation of the series.

Other aspects of the work however have not prospered. Activities on a more spiritual level which were delayed until a firmer foundation could be made as an organization, have never developed. Perhaps as a result of this, the Association is at present just holding its own.

The blame for this belongs to the students themselves. But in the hope that this and other groups may yet succeed, we would like to tell of some of our problems and their possible solutions.

On the student level we operated under the aegis and financial support of the New York Province of the Newman Club Federation. We have felt this to be a burden on them which we did not repay. Their immediate interests on the whole are not ours. We had hoped that locally other professional groups, *i.e.* law, dentistry, would form units inside the Newman Federation. This however has not happened and we find ourselves hungry and but little understood children. We have not achieved the Christian Professional Formation described by *Pax Romana*, the international movement of Catholic students, as being so successful in France.

In that country, the Conference Laennec has a program aimed at the scientific, human and religious formation of the medical student. It assists him in his study of moral and social problems and integrates him to his corporate and apostolic responsibilities. An outline plan of this organization has been published by *Pax Romana*[1].

Our relations with the clergy have been most happy. We received many hours of help from educators, theologians and hospital chaplains. But here

we felt the need for an authority, familiar with medicine, versed in ethics and with the time and interest necessary to be a rallying point for student generations, and the sanctity to aid them to live by moral judgments, once established. Again we think of France and the two full-time chaplains whose "parish" is officially some 2,000 medical students and 1,200 doctors who comprise the Conference Laennec. We have many times heard members of the clergy express their annoyance at difficult relations with individual physicians. Granting the testiness of many physicians, had they not been left to attain their particular religious balance, themselves unaided, easier relations might possibly exist to the benefit of clergy, the physician, and above all, the patient.

The area of our activities which seemed to offer initially the most promise seemed to be liaison with the Catholic Physicians' Guilds. Any difficulties which have been encountered here can perhaps be ascribed to geography. There is no Guild in the Borough of Manhattan, where four of the five medical schools in New York City are located. As a result, membership in the two local Guilds consists almost exclusively of busy practitioners with no present academic connection. Their very membership indicates that they have achieved a spiritual balance in their professional life, but they are far removed from the atmosphere in which, as students, they themselves once needed assistance. Despite these circumstances the Bronx Catholic Physicians' Guild has been most helpful to the Associated Medical Newman Clubs. Their action in making available copies of *Linacre Quarterly* has been a means of introducing students to the current literature of interest to the Catholic physician and also of informing them of the existence and activities of all the Guilds.

Outstanding success has been achieved in Boston among the medical students by the physicians of the Guild of St. Luke. That organization has active members with academic connections and as a result student problems have been understood and student activity fostered, not only on an organizational level as outlined already in a previous issue of this journal[2], but also on the personal level; counseling and direction to training in the specialties being available and research and high scientific standards encouraged.

But it would seem that in the field of inter-personal relationships, the practicing physicians of the Guilds could also accomplish much. The religious and moral values of Medicine are related more to its Art than its Science, and should therefore be more easily transmittable by the practitioner than by the academician.

We would therefore make a plea, even to the busiest of Catholic doctors —to remember the difficulties of his own transition to spiritual maturity—

to remember his oath "to teach them his art, if they want to learn it". We would like to assure him that the busy students also want to learn it. They need his aid in their efforts in a secularistic environment to remain Catholics. to become doctors, and above all, to become *Catholic doctors.*

1. Catholic Faculty Groups in France in *Christian Professional Formation in Theory and Practice, No. 2, Pax Romana*, Fribourg, Switz., 1950.
2. Guild Activities, *Linacre Quarterly* 18: No. 3, August 1951.

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Evidence of interest in other sections of the nation is reported . . . . .

Six members of the Los Angeles Guild are conducting a series of three seminars for the benefit of the students of the local medical schools who would have no other opportunity of formal direction in medical ethics. The efforts of these men are received most enthusiastically. Those doctors responsible for the very worthy venture are: Robert Kelly, M.D., James Kelly, M.D., Clyde Von der Ahe, M.D., Eugene Hoffman, M.D., Joachim Haenel, M.D. and C. Francis Werts, M.D. The Guild will also present some Catholic ethical views to a group of students at UCLA at one of their extra curricular study group meetings.

A course in religious and moral ethics is taught at the State University School of Medicine in Denver, Colorado under the able leadership of Dr. Frank B. McGlone, first President of the Denver Guild. This group also takes interest in the Catholic members of the house staffs of the various hospitals in Denver as well as the Catholic medical students and see to it that they are invited to meetings and have access to LINACRE QUARTERLY.

The Newman Foundation at the University of Minnesota is supplied with the journal, too, by the Minneapolis Guild for the membership there.

Likewise, the Cleveland Guild subscribes for the medical units of the University of Cincinnati, Western Reserve University, Ohio State University and nine medical fraternities in the area.

Obstetricians Offer Mass of Thanksgiving

The time was a day early in January 1944. The place was St. John's Hospital in St. Louis. The administrator was discussing with the staff's chief obstetrician the events of the previous year. Personnel shortages had occurred, supplies had been curtailed—it had been difficult to carry on, giving the usual patient care during a war year. "In spite of all—we have been singularly blessed" the physician was humbly declaring. "We have not lost a mother during these trying months. Thanks be to God for that!"

In pursuing the matter further, the grateful physician wondered aloud if the hospital would help him sponsor a Mass of Thanksgiving and invite all the obstetricians on the staff. Immediate assent was forthcoming. By happy coincidence, the most convenient Sunday closest to the thought was the Feast of the Holy Family and was chosen as the day. Invitations were sent to 14 obstetricians on the staff. This year, for the ninth time, 40 physicians assisted at the Mass.

Frequently internes serve the Mass. Breakfast then follows in the hospital and the priest celebrating the Holy Sacrifice is asked to address the group, honoring the occasion.

1954 will be the 10th anniversary of the Obstetricians' Mass of Thanksgiving. To share this custom with all those who serve in this field, we are reporting this activity with the thought that other Catholic hospitals in co-operation with their staff may be interested in establishing this practice. Without any formal organization, it is hoped that this beautiful ceremony expressing gratitude might become national.

Obstetricians are urged to discuss this with their hospital administrators and if agreeable, make plans for a Mass of Thanksgiving in the hospital chapel on the Feast of the Holy Family in 1954 and annually thereafter.

Annual Meeting of Catholic Physicians

The annual meeting for Catholic physicians will be held Wednesday, June 3, 1953. The occasion is sponsored by The Federation of Catholic Physicians' Guilds but not necessarily limited to membership. All Catholic doctors are cordially invited to attend.

The place—Hotel Commodore, New York City

The time—12:30 p. m.—Luncheon

A short program will follow the luncheon. His Eminence Francis Cardinal Spellman, Archbishop of New York, is to be guest speaker.

If you have not mailed your reservation to date, you are urged to do so at once.

The following letters were prepared for the Medical Staff of Mercy Hospital, Oshkosh, Wisconsin by the Chaplain and the Moral Ethics Committee in the interest of Catholic patients in danger of death. The editors of LINACRE QUARTERLY publish these for their excellence as reminder of an important directive of the ethical code enforced in many of our hospitals.

To the Medical Staff of Mercy Hospital:

The Moral Ethics Committee of the hospital has deemed it necessary to promulgate anew one of the ethical directives of the hospital code in force here. It is this:

> "Everyone has the right and the duty to prepare for the solemn moment of death. Unless it is clear, therefore, that a dying patient is already well prepared for death, as regards both temporal and spiritual affairs, it is the physician's duty to inform, or to have some responsible person inform, him of his critical condition."

The hospital code requires that the physician inform the *patient* either directly or indirectly. The physician, therefore, does not fulfill his obligation by informing the patient's family, unless he is certain that the family will inform the patient. The obligation is to the patient, not to the family.

The hospital code does not require that the patient be informed as soon as his critical condition is discovered, nor does it require that the patient be told the cause of his critical condition. The code merely requires that the patient be told about his critical condition, in sufficient time to prepare for death as regards both his temporal and his spiritual affairs.

The doctor, of course, will be tactful in informing his patient. There is no need for a blunt revelation of his condition. [If the patient is a calm, matter-of-fact, solidly religious person who accepts life and its sorrows with courage and resignation, and he asks what the probabilities of life are for him and how much time he may expect, he might be told with profit. If the patient is unstable, subject to moods that master him to his own detriment, perhaps it will be best to tell him in time to straighten out both spiritual and temporal affairs, but not before, unless he seriously insists upon knowing and claims his right to know. If there is any question whatever of the outcome of the disease, answering queries of impending death by admitting the probability, but showing the possibility of recovery, may buoy the patient's spirit and help him to conquer the onslaughts of his illness.*] Whatever the case, when the proper time comes, the doctor should leave no doubt in the patient's mind that there is danger of death and approximately how great the danger is.

Neglect in observing this part of the code will be considered as serious as neglect in observing the medical directives of the code.

Should the family or relatives sternly object, the doctor can tell them that the moral law and the hospital code require him to inform the patient of his critical condition, and thus divert thier anger from him.

We ask your full cooperation in this matter.

Sincerely yours, (Signed)

Vernon G. Guenther, M.D. — Marcellus C. Haines, M.D.
Ray F. Wagner, M.D. — Earl B. Williams, M.D.

Rev. Dennis A. Worzalla, Chairman

* cf. *Handmaid of the Divine Physician,* by Sister Mary Berenice, O.S.F., R.N., Ph.D., Bruce Publishing Co., 1952, p. 12.

MERCY HOSPITAL

The Chaplain's Postscript:

This letter gives me the opportunity to seek your cooperation in another matter. As the chaplain in a Catholic hospital, one of my chief duties is to administer the last rites of the Catholic Church (Confession, Communion, Last Anointing or Extreme Unction, and the Apostolic Blessing) to dying Catholics. Since I lack medical knowledge and medical acquaintance with the Catholic patients, it is impossible for me to fulfill my duty without the cooperation of the hospital staff.

Heretofore I have had to rely almost entirely on the sisters and the nurses on the floor for notification that a Catholic was in danger of death. They have been very faithful in fulfilling this duty. But they are not always sufficiently aware of the patient's condition, especially as regards new admissions; and as a result there were some "close calls," and more than once the Catholic patient was too far gone to be able to receive all of the last rites.

And so I ask you, too, to cooperate with me that I may fulfill this duty more perfectly. When a Catholic is in danger of death, please notify me, or have the nurse on the floor notify me that I may give him the last rites while he is fully conscious. When there is immediate danger of death, be sure not to administer drugs that will take away the patient's consciousness until after he has confessed his sins, received Holy Communion, and the Last Anointing (Extreme Unction).

Catholics regard the last sacraments as extremely important and beneficial. Very many pray regularly all through their lives that God might allow them to receive the last sacraments before they die. Catholics who receive the last sacraments feel prepared for death. Catholic relatives breathe a sigh of relief and thanksgiving when they hear that the patient received the last sacraments before he died. The last rites bring a certain peace to all involved.

Here is the reason why: Catholics believe that a good confession will take away all the sins for which the penitent is sorry. Moreover, Extreme Unction will give him all the grace he needs to face death courageously and to conquer any temptations that may arise before death. It is also the belief of Catholics that Extreme Unction will take away at the moment of death all the sins that its recipient committed between the time of his last confession and the time of his death, and will cancel out completely his debt of temporal punishment provided he is sorry for all of his sins at least because he fears God's just punishments. In short, Extreme Unction prepares him for immediate entrance into heaven, should death be God's will. Finally, Catholics believe that Extreme Unction has the God-given power to heal the body in some cases. Catholics, therefore, very often have greater hope of recovery because they believe God may cure them through the sacrament of Extreme Unction. Catholics rely on a text from St. James' Epistle for some of this doctrine: "Is any man sick among you? Let him call in the priests of the Church, and let them pray over him, anointing him with oil in the name of the Lord. And the prayer of faith will save the sick man, and if he be in sins they shall be forgiven him" (5:14).

In view of these Catholic beliefs, I think you will agree that your Catholic patients who are dangerously ill will appreciate as much as I, myself, your cooperation in bringing to them the last rites.

Thanks in advance. May God bless you.

Sincerely yours, DENNIS A. WORZALLA

Book Review

Principles of Medical Ethics

JOHN P. KENNY, O.P. Ph.D.

Review by George P. Klubertanz, S.J.
Dean of the College of Philosophy and Letters
Saint Louis University

CATHOLIC physicians, particularly those concerned with medical education, are constantly on the lookout for books that will help them to understand better their position as Catholics in the profession, and to explain themselves to those not of the Faith. This book will be of some use, though it also has some limitations.

"Ethics" is understood by the author to be Catholic ethics, that is, it bases its principles not only on the data of reason but also on those of revelation, and makes use of the decisions and pronouncements of the Church concerning specific practices. Moreover, the author tries to be fairly complete—to cover the major areas of medico-moral problems. In general, his procedure is this: he states the problem briefly, sometimes illustrating it with a case; he explains the facts and principles which enter into the moral consideration of the problem, and then states his conclusion in the form of a moral principle. The argumentation and the conclusions are characterized by respect for tradition and soundness of judgment. If a doctor or nurse is looking for a convenient compendium for guidance in the more ordinary problems of medical and nursing practice, this book can be highly recommended.

The limitations of the book correspond to its excellencies. It is very brief, and its already scanty space is restricted further by the presence in the book of two chapters (32 pages) devoted to general ethical principles and the general considerations of justice and charity. Furthermore, the explanations of the moral principles frequently are couched in technical terms which are not adequately explained in non-technical language. Hence, a teacher using the book as a text would have to make sure that these terms are understood by the students.

But Catholics should be cautious in giving this book to interested inquirers who have no background in Thomistic philosophy. Several instances will make this clear. The doctrines of the morality of material cooperation and of the double effect are almost universally accepted among Catholic writers. These doctrines are valid principles for the solving of certain moral cases, because of the nature of the will act and its relation to its object. Suppose a person has no clear understanding of the activity of the will, and cannot meaningfully distinguish between an object willed materially and one willed formally. These principles will then look to him like sheer quibbling or like laxism.

Again, the evil of suicide and murder are commonly said to lie in this, that they violate the exclusive dominium of God over human life. Why should it be morally good to save a life or lengthen it by interfering with natural causes, though it is morally wrong to destroy or shorten life by a similar interference? Of course, this is not a good question in the mind of one who has any understanding of Divine Providence and the place of man's ingenuity and freedom within the plan of God. But many non-Catholics (and, I fear, some Catholics, too) do not understand these things, and are not satisfied with what, to them, is a mere word.

Finally, consider the arguments based on the frustration of the natural use of a faculty. This is a self-evident principle, true; but its self-evidence does not consist in an enunciation of the words which express it. And when a culture has discarded the whole notion of natural finality, then terms like "frustration," "natural," "unnatural," and so on, become mere words, to be viewed with suspicion, and to be interpreted as evidences of blind, unreasoning authoritarianism.

Unfortunately, this reviewer does not know where the desired explanations are to be found, short of complete treatises on the philosophy of being (metaphysics) and of man.

PRINCIPLES OF MEDICAL ETHICS
published by Newman Press, Westminster
1952, pp. XIII and 208, $3.25

Guild Notes

The Federation welcomes a new member . . . . A hearty greeting is extended to the Los Angeles Catholic Physicians' Guild. Affiliation with the Federation took place in March. The activities of this Guild are taking on proportions of influence in local medical circles as an account will reveal. Another article in this issue of *Linacre Quarterly* reports the seminars being conducted for the benefit of the students of the medical schools there and the interest taken in the students at UCLA.

The Guild is making an effort to forward useful medical samples to some of the impoverished far western Indian missions and invites any members of the Federation who may have samples of this type to send them to: Franciscan Fathers, Navajo Mission, St. Michaels, Arizona. They must be mailed Express through Gallup, New Mexico.

The members of the Guild made a retreat at Manresa in Azusa, California during Holy Week.

On May 9, the spring banquet was held at which time His Eminence John Francis Cardinal McIntyre was honored for his personal efforts in the inauguration of the Guild in his archdiocese.

The Federation is glad to report the activities of its latest member Guild and extends best wishes for a year of important accomplishments and growth.

The Officers of the Los Angeles Catholic Physicians' Guild are: Reynolds J. O'Donnell, M.D., Santa Monica, President; Edmund F. Cain, M.D., Anaheim, Vice-President, and C. Francis Werts, M.D., Los Angeles, Secretary-Treasurer.

Sacramento Guild presents full program . . . . . At the annual business meeting of the Catholic Physicians' Guild of Sacramento held in January, the following officers were elected: Chaplain, Father Thomas Markham; President, Dr. John G. Walsh; Vice-President, Dr. John Berg; Secretary, Dr. John Connors; Treasurer, Dr. John Babich; Directors, Dr. Leo Farrell, Dr. Herman Lorenz and Dr. Manuel Azevedo.

For May, the annual Communion Breakfast is to be held at the residence of Bishop Robert Armstrong.

In September the Guild will hold a joint meeting with the Mercy Hospital Staff at Mercy Auditorium. Father William Donnelly, Professor of Moral Theology at Alma College, will be invited to speak and present actual cases from his files.

In October a Day of Recollection will be held at the Sisters of Mercy Motherhouse in Auburn. The retreatmaster will be announced. Tentative plans are to have an evening Mass to conclude the retreat. Non-Catholic doctors on the Mercy Hospital Staff will be welcome to attend.

The year's final event will be a dinner meeting to be held at Mercy Hospital Auditorium. The Guild members will be guests of the Sisters.

All these activities are reported in a letter sent to the members of the Catholic Physicians' Guild of Sacramento, with dates and chairmen listed, giving them full particulars for handy reference. The officers have thoughtfully planned a varied program which we report for help to other Guilds.

Denver Guild includes majority of Denver Catholic physicians in membership . . . . . Dr. T. A. Duggan, Secretary of the Denver Guild, reports that the group there has 75 very active members from a potential of some 80 Catholic physicians in the city of Denver, in its second year of organization . . . . certainly an excellent representation. The new officers are: A. S. Cecchini, M.D., President; J. B. McLoskey, M.D., Vice-President; John G. Hemming, M.D., Treasurer, and T. A. Duggan, M.D., Secretary.

The three annual events for the year are a Day of Recollection in September at St. Thomas Seminary; a dinner in February featuring a noted speaker, sponsored by the Guild, and another dinner meeting in April sponsored by Archbishop Urban Vehr.

In addition, a course in religious and moral ethics is taught at the State University School of Medicine in Denver under the leadership of Dr. Frank A. McGlone, the Guild's first President.

The group also takes an interest in the Catholic members of the house staffs of the various hospitals in Denver as well as the Catholic medical students and sees to it that they are invited to the meetings and that they have access to *Linacre Quarterly.*

Several of the members have contributed to scientific publications during the past year; special mention is made in the report of Dr. McGlone, Dr. Louis Barbato, Dr. J. P. Clarke, Dr. R. E. Hays and Dr. John E. Gardell as some of the authors.

Brooklyn Guild reports . . . . a Clinic Day was resumed by the Brooklyn Guild after a lapse of several years. It was held at St. Catherine's Hospital, with round table discussions on topics of general interest in the morning; in the afternoon a series of papers was presented by the members.

The yearly retreat at Mount Manresa was attended by 80 of the doctors.

The fall of the year included a social event—a golf day and dinner.

Welcome is also extended to the Catholic Physicians' Guild of Portland,

Oregon which has become affiliated with the Federation. Officers for this group are: President, Thomas Fox, M.D., Vice-President, James Foley, M.D.; Secretary, Paul Zuelke, M.D., and Treasurer, Bernard Harpole, M.D. Reverend L. J. Derouin, Chaplain, is lending whole-hearted effort to the organization's activities and is greatly instrumental in its formation. May success follow the pathway of this Guild and all plans for progress be fulfilled.

This One Is Too Good to Miss!

Of interest to our subscribers should be the new THEOLOGY DIGEST *published by St. Mary's College, the School of Divinity of St. Louis University. Gerald Van Ackeren, S.J. is the Editor.* THEOLOGY DIGEST *is published for priests, religious, seminarians and laity who are interested in present-day theological thought. The Editorial Staff aims to keep such readers informed of current problems and developments in theology by presenting a concise sampling of current periodical writings in theology. Articles are selected for their significance, interest and digestibility, after a thorough examination of most of the theological journals in Europe and America. The articles are carefully translated and condensed so as to represent accurately and succinctly the thought and spirit of the original. The digests deal with the various branches of theological learning—Apologetics, Dogmatic Theology, Scripture, Moral Theology and Canon Law, Ascetics, Liturgy, and Church History—with emphasis on the speculative rather than the pastoral aspects of theology.*

THEOLOGY DIGEST *is published in the Winter, Spring and Autumn of each year. Subscription price in U. S., Canada and countries of the Pan-American Union, $2.00. Foreign, $2.25. Single copies, 75c. Business address for subscriptions is:* THEOLOGY DIGEST, *1015 Central, Kansas City 5, Missouri.*